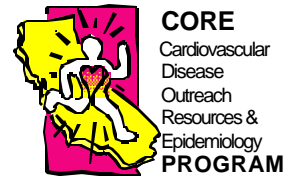


HEART DISEASE & STROKE AMONG WOMEN IN CALIFORNIA AND THE U.S.



Why do women need to know about heart disease & stroke?

- Because if current trends continue, it will kill almost 1 in 2 of them.
More women die from heart disease and stroke than from the next 16 causes of death *combined*.¹
- Because when heart disease strikes, it may not give a warning.
The Framingham Heart Study found that two-thirds of sudden deaths due to coronary heart disease in women occurred in those with no previous symptoms. For these women, who may not make it to a hospital, primary prevention is the only solution.²
- Because women are under-diagnosed and under-treated for heart disease.
Gender differences in the symptoms of heart disease, and lessened accuracy of diagnostic tools, contribute to this problem.²
- Because women can take action to reduce their risk.
Changes in lifestyle can reduce a woman's chance of developing heart disease or suffering a stroke. Research has shown that reducing the number of risk factors significantly diminishes the risk of CVD. For example, if a woman has three risk factors (such as high blood cholesterol, smoking, and overweight) the risk is 20 times as great as that for a person with no risk factors; if she has two risk factors, the risk is 6 times as great.³
- Because women can take action to protect their families.
Heart disease begins in youth.⁴ In addition, adult children of women with premature coronary heart disease may be at greater risk than those of men with CHD. These adult children also may have a high prevalence of modifiable risk factors, and may not believe themselves to be at risk of heart disease.⁵

Multiple factors contribute to heart disease & stroke risk

Research shows that elevated blood cholesterol, smoking, high blood pressure, and lack of regular physical activity raise the risk of heart disease and stroke. Other factors, such as having uncontrolled diabetes or being overweight, also increase risk.

IN CALIFORNIA

- Smoking is more prevalent among African American women than among any other race-gender group. 26.8% of African American women in California smoke, as opposed to 19.2 % of white women.⁶
- High blood pressure is more prevalent in African American women (35%) compared with Latino (25%) White (23.7%) and other women (21.5%).⁶
- Diabetes is more prevalent among African Americans (14.5%) than any other ethnic group (Hispanics-12.9%; Whites-4.3%; Other- 7.6%).⁶
- Obesity is prevalent among 42.7% of Latino women and 40.2% of African American women, as opposed to 24.2% of White women.⁶

What can be done to reduce women's risk of heart disease & stroke?

*Community-based CVD risk reduction efforts can influence behavior on a broad scale.*⁷

INDIVIDUALS

- Can modify their lifestyles by not smoking; eating a lowfat, high-fiber diet; controlling high blood pressure; maintaining a healthy body weight, and staying physically active.³

COMMUNITY ORGANIZATIONS that include or serve women

- Can make changes to foster a heart-healthy environment.⁸ For example, they can prohibit smoking on the premises, serve low-fat foods at community events, or allow flex-time to encourage exercise.

HEALTH CARE PROFESSIONALS who serve women

- Can fully implement the medical screening and counseling recommendations contained in the *Clinician's Handbook of Preventive Services, 2nd Edition*, using materials such as "Put Prevention Into Practice," a tested model to remove barriers for preventive screening.⁹

WOMEN'S ADVOCATES

- Can help politicians, the media, and other key decision-makers understand that comprehensive heart disease and stroke prevention efforts must extend beyond treating late stage disease.¹⁰ It is also necessary to address barriers such as access to nutritious foods, recreational space, and health care.

¹ American Heart Association. *1999 Heart and Stroke Statistical Update*. Dallas, TX: American Heart Association, 1998.

² American Heart Association. *Cardiovascular Disease in Women: A Statement for Healthcare Professionals from the American Heart Association*. Dallas, TX: American Heart Association, 1997.

³ Hernandez M, Gazzaniga JM, eds. *Heart Disease and Stroke Fact Finder: Of Special Interest: Cardiovascular Disease and Women*. Cardiovascular Disease Outreach, Resources and Epidemiology (CORE) Program. Sacramento: California Department of Health Services and University of California, San Francisco, 1996.

⁴ Strong, J.P.; Malcome, G.T.; McMahon C.A.; Tracy, R.E., Newman, WP, Herderick, E.E., Cornhill, J.F. *Prevalence and Extent of Atherosclerosis in Adolescents and Young Adults: Implications for Prevention from the Pathobiological Determinants of Atherosclerosis in Youth Study*. JAMA 1999; 281: 727-735.

⁵ Allen JK; Blumenthal RS. *Risk factors in the offspring of women with premature coronary heart disease*. Am Heart J. 1998 Mar; 135(3): 428-34.

⁶ Gazzaniga JM, Kao C, Cowling DW, Fox P, Davis B, Wright WE. *Cardiovascular Disease Risk Factors Among California Adults, 1984-1996*. CORE Program, University of California San Francisco and California Department of Health Services, Sacramento, CA 1998.

⁷ Stone EJ, Pearson TA, Fortmann SP, McKinlay JB. *Community-based Prevention Trials: Challenges and Directions for Public Health Practice, Policy, and Research*. AEP Vol 7, No S8; October 1997: S114-S120.

⁸ McKinlay JB, Marceau LD. *A Tale of 3 Tails*. Am J Pub Health; March 1999, Vol 89, No.3.

⁹ *Put Prevention into Practice*. Overview. Agency for Health Care Policy and Research, Rockville, MD. <http://www.ahcpr.gov/ppip/ppipover.htm>

¹⁰ Schooler C, Farquhar JW, Fortmann SP, Flora J. *Synthesis of Findings and Issues from Community Prevention Trials*. AEP, Vol 7, No S7. October 1997: S54-S68.